

New Jersey Project LAUNCH

Linking Actions for Unmet Needs in Children's Health

Urban Essex County Strategic Plan



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Table of Contents

Introduction and Frame	2
Mission, Vision, and Values (Template 5)	6
Goals and Objectives (Template 6)	7
Implementation and Sustainability Strategies (Template 7)	8
Logic Model	17

INTRODUCTION AND FRAME

NJ Project LAUNCH (NJPL) and Essex Pregnancy and Parenting Connection (EPPC), the local lead agency for Essex LAUNCH, have developed this preliminary strategic planning document by building upon the recently completed needs assessment and environmental scan, as well as, drawing upon related state and local planning efforts. The following subsections provide a brief summary of the process and key steps that have been used to establish the framework for the *Essex LAUNCH Strategic Plan*.

A. Engage Stakeholders: This plan is the result of input from a broad array of state and local stakeholders, including family members and other caregivers, as described in the Urban Essex County Environmental Scan (submitted 2/2/14). EPPC has collected information from stakeholders through key informant interviews and meetings, as well as through our ongoing participation in local community initiatives led by other agencies over the past six months. These stakeholders have included: healthcare providers, early childhood educators, social service providers, home visitors, policy-makers, community workers, parents/consumers, non-profit leaders, local funders, and others.

B. Gather Existing Information to Inform the Process: As described in the Essex County Environmental Scan, a variety of methods were used to gather data, including updates of existing documents—e.g. the NJ Home Visiting needs assessment and Newark Kids Count publication. Essex County early childhood planning efforts also included focus groups/survey to gather feedback from the community, including parents and caregivers, providers, and key stakeholders.

The strategic planning process in Essex builds upon recent planning activities and incorporates existing resources, services, supports, policies, and programs that can be leveraged to help address identified issues and concerns. In preparation for the planning process, NJPL leaders have conducted several orientation sessions to early childhood stakeholders and council members at both the state and local levels. NJPL is working closely with Essex LAUNCH to ensure that strategic planning, local goals and objectives, and proposed strategies are aligned with related statewide early childhood efforts, such as. NJ's Early Childhood Comprehensive System (ECCS) process, Maternal Infant and Early Childhood Home Visiting (MIECHV) State Plan, and the Race To the Top-Early Learning Challenge (RTT-ELC) Early Learning State Plan.

C. Conduct Strategic Analysis of the Environmental Scan: NJPL and Essex partners completed a preliminary analysis that now informs the development of the Essex LAUNCH Strategic Plan--refining goals, objectives, and outcomes; core implementation strategies; and key evaluation questions. Highlights from the recent environmental scan are summarized here:

- NJPL/Essex LAUNCH will build upon current efforts (state and local) in planning, service expansion and systems integration in related early childhood prevention efforts—prenatal/perinatal health, infant/child health, behavioral health, and early care and education.
- Essex County has an abundance of resources as evidenced by the Essex Environmental Scan. The challenge will be to work with core partners to develop a fully integrated system of care

that will better serve residents—pregnant women, parents/families, infants and young children; and simplify the referral and communication/feedback process for providers.

- It is imperative that programs and resources are aligned to optimize the quality of early education and care to maximize the benefit for infants, young children and their families.
- EPPC will lead the local efforts to improve and integrate systems and enhance services will include all key caregivers and settings where services/supports for young children are located—public clinics, private health care practices, behavioral/mental health agencies, child/family welfare, community-based agencies, home visiting programs, child care centers, family resource centers, family child care providers, family/friend and neighbor care, Head Start/Early Head Start, public/private preschools, and local schools/school districts, special child health services, early intervention, special education, and other family support services.
- Project LAUNCH will maintain a population focus (prenatal/child developmental screening), but will also strengthen linkages for specific subpopulations of pregnant women, infants and young children in Essex County that are more vulnerable to health disparities because they may face greater obstacles to care based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability and/or have been adversely affected due to systems discrimination or exclusion.
- The overarching goal for NJPL and Essex LAUNCH is to reduce and ultimately eliminate differences in access, service use, and outcomes within identified subpopulations.

D. Review and Refine Vision, Mission, Project Values Statements, Goals, and Objectives:

Please refer to **Template 5** on **page 6** for the **Mission, Vision, and Project Values Statements**. The **Goals and Objectives** are located in **Template 6** on **page 7**.

E. Refine the Logic Model, Including the Outcomes and Indicators: Please refer to the last page of the document for the updated Project LAUNCH/Essex LAUNCH **Logic Model-page 17**.

F. Develop or Refine Program and Policy Strategies: NJPL and Essex LAUNCH projects will incorporate evidence-based programs (EBP) and services that meet the needs of current children and families in the Essex LAUNCH target community.

Throughout the last three months of Year 1 (June through August 2014), the Essex LAUNCH Steering Committee will convene to refine the strategic planning process. Selection of specified EBPs will be finalized by July 1, 2014 (RFP pending) at which time additional input into the strategic plan will be sought from core stakeholders with an eye toward identifying key indicators and benchmarks for model start-up, implementation and fidelity. Local stakeholders will revisit goals and objectives for selected EBPs and make needed adjustments based on the final selection of evidence-based programs.

Please refer **Template 7** on **pages 8 to 16** for an overview of the **Program and Policy Strategies** that will be implemented to reach our goals and objectives.

G. Identify Policies and Procedures to Address Health Disparities: As noted in the NJ Project LAUNCH Disparities Impact Statement (DIS) the priority cities within Essex County include Newark, Irvington, East Orange and Orange. To successfully reduce behavioral health disparities, New Jersey’s strategic plan will ensure that outreach and service delivery is responsive to the cultural and linguistic needs of sub-populations within the target area—African-American ethnicities include Haitian and Nigerian immigrants; and predominant Hispanic/Latino ethnicities include Puerto Rican, Ecuadorian, Dominican and Portuguese.

Essex LAUNCH will work to improve infant and child health outcomes ensuring: a) links for children to health insurance and pediatric medical home, b) routine developmental screening (e.g. Ages & Stages Questionnaire), and c) early linkage to evidence-based health and social support programs—i.e. home visiting, Head Start; child care services (subsidies for low income families); and services for special needs—early intervention, infant/early childhood mental health, child behavioral health, special education; or other child/family supports.

Essex community partners have begun to meet to discuss collaborative outreach efforts to ensure that pregnant women, families with young children have easy access to services through the proposed expansion of the EPPC central intake (single point of entry). A key element of the plan is for a universal screening process (prenatal/pediatric) that is not biased based on race or ethnicity, but rather objectively identifies the need for supports and service linkages.

PLNJ Services (DIS Target Numbers) Essex County – Target Cities	Total	FY2014	FY2015	FY2016	FY2017	FY2018
Direct Services: Number to be served	14,000	baseline	3500	3500	3500	3500
ASQ (age 6 mo. to 5 years old) - 10,000 est.						
4 P’s Plus (pregnant women) - 4,000 est.						
By Race/Ethnicity						
African American Non-Hispanic (60%)	8,400	baseline	2,100	2,100	2,100	2,100
American Indian/Alaska Native (<.5%)	<20	baseline	<5	<5	<5	<5
Asian – Non-Hispanic (<1%)	<100	baseline	<25	<25	<25	<25
White – Non-Hispanic (4%)	560	baseline	140	140	140	140
Hispanic or Latino (33%)	4,600	baseline	1,150	1,150	1,150	1,150
Native Hawaiian/Pacific Islander (<.5%)	<20	baseline	<5	<5	<5	<5
Two or more Races – Non-Hispanic (2%)	280	baseline	70	70	70	70
By Gender						
Female (women, plus female children)	9,000	baseline	3500	3500	3500	3500
Male (male children)	5,000	baseline	1250	1250	1250	1250
Transgender	unknown	unknown	unknown	unknown	unknown	unknown
By Sexual Orientation/Identity Status						
Lesbian	unknown	unknown	unknown	unknown	unknown	unknown
Gay	unknown	unknown	unknown	unknown	unknown	unknown
Bisexual	unknown	unknown	unknown	unknown	unknown	unknown

In collaboration with funded partners (RFP pending), NJPL / Essex LAUNCH staff will further develop this section of the plan to identify specific activities that align with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care to address how recruitment policies of new programs align with client culture and languages; employee and other staff cultural competence trainings; translation services and protocol for family input and satisfaction surveys.

H. Plan Financing and Sustainability: New Jersey has strong leadership and well-established relationships across sectors that will support help to a feasible sustainability plan for NJ Project LAUNCH / Essex LAUNCH. This initiative is well-timed and will be fully aligned with a larger early childhood vision that is developing in our state. DCF, the lead agency, is a co-collaborator with other state departments for several related initiatives. These include: NJ Early Learning Commission (four core state departments that meet regularly to integrates EC services and supports), Early Childhood Comprehensive Systems (ECCS) , Help Me Grow (HMG), Title V MCH Block Grant, Community-based Child Abuse Prevention (CBCAP), NJ Council for Young Children (NJCYC). NJ’s new Race To the Top Early Learning Challenge (RTT-ELC) grant (January 2014), and the accompanying NJ Early Learning State Plan that includes Grow NJ Kids (tiered quality rating and improvement system) include two key elements that directly link with LAUNCH--health screening/linkage and parent/family engagement.

As Essex LAUNCH moves forward, state and local partners will work together with our state evaluator to determine the effectiveness/cost-benefit of core service elements; and use this data to drive sustainability efforts. The ongoing strategic planning process will solicit partner input to explore potential funding opportunities to help sustain proven/promising services and supports that meet critical needs and address barriers to care. These may include governmental (federal/state/local) and nongovernmental (private foundations/corporate business support) funding, or volunteer support.

I. Identify Tasks and Move Forward: Please refer to **Template 7** on **pages 8 to 16** for the next steps and timeline for the initial six to 12 months of NJ Project LAUNCH/Essex LAUNCH. As noted above, this document is a *preliminary* plan based on the work completed thus far. We have informed our local stakeholders that the process will become more inclusive and soliciting greater local input once DCF completes the Request for Proposals (RFP) process. This is a state requirement that helps to ensure a fair and objective competitive bidding process.

NJPL will incorporate a structured mechanism through the YCW Council Steering Committee to revisit the plan on twice a year (and as needed), and use it to inform ongoing decision making helps to ensure that the work on the ground reflects the stakeholders’ strategic direction.

The submission of this strategic plan to SAMHSA does not complete the planning process—it will be ongoing both in terms of the development of the plan and its revision over time as goals and objectives are met and new ones are identified. An updated strategic plan will be provided to SAMHSA annually throughout the life of the grant.

Template 5: Mission, Vision, and Project Values Statements

The mission of Essex LAUNCH is to link and enhance efforts to improve overall young child wellness in urban Essex County. This will be accomplished by providing culturally competent, evidenced-based programs that address the physical, social, emotional, behavioral and cognitive well-being of children ages 0-8. And, by providing targeted training and the necessary tools for families, and early childhood partners across sectors—health/behavioral health, home visiting, childcare and early childhood education, early intervention, infant-child mental health, child welfare and family support—to create a comprehensive, coordinated system that supports child and family health and eliminates racial and ethnic disparities.

Vision: When Essex LAUNCH is successful, there will be reduced health disparities, reduced duplication of services, and a streamlined and seamless system of young child wellness for families in the four target cities in urban Essex County. Young child wellness stakeholders (providers and families) will work together to ensure that infants and young children in their care are linked to high-quality services and supports that promote their optimal physical, social, emotional, behavioral and cognitive wellbeing.

The values of Essex Project LAUNCH initiative are as follows:

- Culturally- and linguistically-competent services that are equitable, respectful, and responsive to the diversity of our community
- Services that are guided by an appreciation of the fundamental value and dignity of every child and his/her family
- Services that are child-centered, family-focused, community-based and adapted to our four cities and their distinct needs, challenges, and strengths
- The elimination of health disparities among all groups, and the improvement in access, service use, and outcomes among subpopulations, particularly ethnic and linguistic minorities

Template 6: Goals and Objectives

Goals and Objectives		Priority Goals & Objectives
Proposed in Grant Application	Updated	
Goal 1: Improve access to and use of screening and assessment, across a range of settings.	Goal 1: Improve access to routine screening & assessment across a range of settings (e.g. primary care, home visiting (HV), child care, preschool) to promote early identification of health & developmental issues that impede child wellness.	Priority
Objective 1.1: Increase use of ASQ and ASQ:SE.	Objective 1.1: Increase use of a valid and reliable tools developmental screening tool across child health and other child-serving settings for children (from birth to 5 years) in urban Essex County.	Priority
Objective 1.2: Increase use of 4Ps Plus prenatal screening for alcohol use, depression and DV.	Objective 1.2: Increase use of Perinatal Screening and Risk Assessment (PRA) and 4 Ps Plus prenatal screen for alcohol, tobacco and other drug (ATOD) use, perinatal depression and domestic violence.	Priority
Goal 2: Improve early care & education (ECE) and primary care assessment of child behavioral health.	Goal 2: Improve workforce knowledge and application of infant/early childhood mental health (IECMH) principles within child serving sectors—pediatric primary care and community-based settings, i.e. Home Visiting, Head Start).	Priority
Objective 2.1: PCPs participate in <i>Educating Physicians in the Community</i> and <i>Help Me Grow</i> .	Objective 2.1: Pediatric/family practice primary care providers (PCP) will improve parent/family access to and use of pediatric primary care for assessment of infant/child social-emotional & behavioral health (BH).	Priority
Objective 2.2: ECE staff participate in CSEFEL and Infant Mental Health Training.	Objective 2.2: Early care & education community providers will improve parent/family access to IECMH and child BH services. ECE staff will participate in Infant Mental Health and Pyramid Model trainings	Priority
Goal 3: Expand EBPs that support parent-child interaction and young child development.	Goal 3: Ensure that parents/families have access to a continuum of community-based evidence-based programs (EBP) that support parent-child interaction and child development, with a special focus on infant/ young child social-emotional health and wellness.	Priority
Objective 3.1: Increase referrals for pregnant woman and children to age 8 to central intake.	Objective 3.1: Increase the success of current Essex HV programs in reaching NJ's established participation rate and HV performance benchmarks for parents/ families with children pregnancy/birth to age 3.	Priority
Objective 3.2: Increase referrals to HV and alternate community-based family support settings.	Objective 3.2: Increase access for parents/ families with children (birth to age 8) to alternate community-based early childhood/family support settings—to include Essex LAUNCH EBPs (TBD), Early Head Start/Head Start, Family Success Centers, Child Care, Family Child Care, preschool.	Priority
Goal 4: Increase opportunities for family strengthening & parent leadership.	Goal 4: Increase opportunities for family strengthening programs and parent/family leadership development.	Priority
Objective 4.1: Develop a stronger participatory & advisory role for parents/families using the SF Protective Factors Framework.	Objective 4.1: Develop a stronger participatory & advisory role for parents/families using the Strengthening Families (SF) Protective Factors Framework.	Priority

Template 7: Implementation and Sustainability Strategies

<p>Goal 1: To improve access to routine screening and assessment across a range of settings (primary care, home visiting, child care, preschool, etc) to promote early identification of health and developmental issues that impact on child wellness.</p>			
<p>Rationale: Low levels of use of valid and reliable screening tools during pregnancy and early childhood. Lack of coordination of screening, assessment and linkage to necessary services across home visiting, early care and education, and prenatal and primary health care settings.</p>			
<p>Objective 1.1: Increase the use of a valid and reliable tools developmental screening tool across child health and other child-serving settings for children (from birth to 5 years) in urban Essex County.</p>			
<p>Targeted Outcomes: In Years 2 thru 5, increase use of standardized screening instruments (ASQ or other valid/reliable tools) by primary health care professionals, home visitors, childcare providers and other child-serving settings by at least 25% per year (target minimum of 2,500 children annually—total of 10,000 children). Ensure appropriate follow up for at least 90% of the children identified as being at risk for developmental delays.</p>			
<p>Major Indicators: Inventory current use (# sites / setting / # children / frequency / tool) to establish accurate baseline. Track # of children screened, # screens completed, frequency; referrals to EI. Finalize with input from evaluation.</p>			
General Strategy	Activities/Tasks	Stakeholders Responsible	Timeframe
<p>Conduct targeted training on ASQ and ASQ:SE and other valid and reliable tools (as determined by partners) to pediatric health professionals and others serving young children in the community.</p>	<ul style="list-style-type: none"> • Identify physicians and practices in collaboration with YCWC, SPAN, and NJAAP and extend invitation to join screening group • Include state partners to ensure alignment with NJ efforts. • Develop meeting plan, including frequency of meetings, location, facilitator, and agenda for first meeting (May). • Hold monthly meetings between June and September with goal of developing local training and implementation plan. • Complete an inventory of current use / establish baseline data • Address training logistics (participants, location, etc.) and offer training to local providers (July-Sept). Begin expansion (Dec). • Track and monitor progress. • Provide input from training/implementation with the state to inform statewide expansion (align with ECCS). 	<p>YCWC screening workgroup, Essex YCW Coordinator, pediatric health professionals, NJ AAP, Medicaid managed care organizations (MCOs), home visitors, EHS/HS, CCR&R, preschools, Early Intervention (EI), & parents/ consumers</p> <p>State partners – DCF (ECCS/HMG), DOH, DHS, and DOE, NJCYC</p>	<p>Physician outreach & training June-September 2014</p> <p>Begin to implement October-December 2014</p>
<p>Policy Implications: Coordination of screening efforts across related services, including home visitation, early intervention, and primary care practices. Linkage of providers of screening tools to providers of EI services based on screening results.</p>			
<p>Work Force Implications: Coordination of training efforts for early childhood professionals across sectors, including mental health consultants, home visitors, childcare providers (home and center based) and pediatric health professionals to build developmental screening capacity.</p>			

<p>Coordination and Collaboration with the State: Input from relevant state-level work groups, such as the NJCYC Infant/Child Health Committee and Physician/Healthcare Workgroup (ECCS,/HMG, COCC, NJAAP, EI, HV) to align with state efforts.</p>
<p>Coordination and Collaboration with Other Stakeholders: Input from local partners through the Essex YCW Council including local public health leaders, pediatric health professionals, and families/consumers to determine most appropriate screening instruments to be used. Local collaboration with AAPNJ to facilitate training of pediatric health professionals.</p>
<p>Addressing Behavioral Health Disparities: Pilot will begin with basic child developmental screening using a valid/reliable screening tool (e.g. ASQ) and progress to including a tool that identifies social-emotional delays/behavioral concerns (e.g. ASQ:SE). Particular attention will be given to ensure that services are responsive to the cultural and linguistic needs of sub-populations as identified in the Disparities Impact Statement (DIS)--African-Americans, Haitian and Nigerian immigrants; and the predominant Hispanic/Latino ethnicities including Puerto Rican, Ecuadorian, Dominican and Portuguese.</p>
<p>Enhanced National CLAS Standards Alignment: Ensure cultural competency training for providers conducting screenings; and assess the need for communication and language assistance for parents/families. Parent-completed screening tools and questionnaires will be available in the various languages and literacy levels appropriate to the populations being served.</p>
<p>Sustainability Strategies: Determine current policies and funding mechanisms—Medicaid/NJ FamilyCare, EPSDT, MCOs. Continue local coordination across sectors, Track cost-benefits of screening. Additional funds may not be needed.</p>
<p>Objective 1.2: Increase use of the Perinatal Screening and Risk Assessment (PRA) and 4 Ps Plus prenatal screening tool for alcohol, tobacco and other drug (ATOD) use, perinatal depression and domestic violence.</p>
<p>Targeted Outcomes: In Years 2 thru 5, prenatal care providers will increase their use of the PRA, which includes the valid and reliable 4 Ps Plus a standardized screening instrument tool for ATOD use, perinatal depression and domestic violence, by <i>at least</i> 40% per year. Baseline for 2013=1,000 <u>pregnant</u> women annually—target of 4,000 pregnant women annually by 2018. (Note: total annual births are estimated at 8,000).</p>
<p>Major Indicators: In Year 1, complete an inventory of current use (# sites / # women) of PRA and subsection with the 4 Ps Plus to establish baseline. Identify # of pregnant women screened at least once during pregnancy. SPECT (Single Point of Entry Client Tracking) data system will be used to determine baseline and track increases in system-wide utilization of the PRA form and 4 Ps Plus screening component by prenatal care providers and other community partners.</p>

General Strategy	Activities/Tasks	Stakeholders Responsible	Specific Timeframe
<p>Conduct targeted training of prenatal care providers and other stakeholders across the community on use of the PRA, including specific guidelines on completing the 4 Ps Plus.</p>	<ul style="list-style-type: none"> Identify prenatal providers to join YCWC screening work group, include state participation to ensure alignment with state efforts (thru June). Develop meeting plan, including frequency of meetings, location, facilitator, and agenda for first meeting (May). Hold monthly meetings (June – Sept) with goal of developing local training & implementation plan. Address training logistics (participants, location, etc.) and communicate to local community (July). Reinforce training to local prenatal providers (October-December). Track data, monitor progress & adjust (ongoing) Provide feedback from training/ implementation with the state to inform statewide expansion. 	<p>Local YCWC screening workgroup, prenatal care providers, MCH Consortium, Risk Reduction Coordinator, CHWs, EPPC staff, Medicaid MCOs, Improving Pregnancy Outcomes (IPO) partners, service providers in areas of ATOD, DV, and mental health.</p> <p>State partners – DCF (ECCS/HMG), DOH, DHS, Family Health Initiatives (SPECT System), March of Dimes, NJCYC.</p>	<p>Complete inventory of current use (#sites / #women) of 4 Ps Plus (May-July)</p> <p>Physician outreach & training June-September 2014</p> <p>Begin to implement October-December 2014</p> <p>Increase use of PRA and 4 Ps Plus tracking thru EPPC (Central Intake). (quarterly)</p>
<p>Policy Implications: Coordination with State partners to promote routine use of the PRA (including the 4 P’s Plus) as a component of quality prenatal care. Consider efforts to incentivize 4 Ps Plus screening for prenatal care providers currently not using tool. Collaboration with related partners— NJ Medicaid MCOs, March of Dimes, ACOG/physician groups, and others-- to increase PRA usage in hospital/community-based clinics, FQHCs, and private care settings.</p>			
<p>Work Force Implications: Conduct local countywide training (perhaps bring Dr. Ira Chasnoff to present to physician partners) to broaden outreach to interested prenatal providers on 4 Ps. Build linkages with other champions NJ Section of ACOG to expand PRA use and compliance.</p>			
<p>Coordination and Collaboration with the State: Input from relevant state-level groups, such as the NJCYC Infant/Child Health Committee and Central Intake Workgroup (ECCS,/HMG, HV) to align with state efforts. Participation from NJ DCF, DOH, DHS, and Family Health Initiatives (for SPECT training and support).</p>			
<p>Coordination and Collaboration with other Stakeholders: MCH Consortium, ACOG-NJ Section, ACNM-NJ Section, AWOHNN, FQHCs, Centering Pregnancy/Strong Start sites, University Hospital, Newark Beth Israel to increase PRA use for pregnant women</p>			
<p>Addressing Behavioral Health Disparities: PRA and 4 P’s Plus will help to identify risk factors, and provide opportunities to offer prevention education and earlier linkages for pregnant and parenting women/families in need of health/behavioral health and family support services.</p>			
<p>Enhanced National CLAS Standards Alignment: Ensure cultural competency training for providers conducting screenings; and assess the need for communication and language assistance for parents/families. Particular attention in will be given to ensure that services are responsive to the cultural and linguistic needs of sub-populations as identified in the DIS: African-Americans, Haitian and Nigerian immigrants; and predominant Hispanic/Latino ethnicities-- Puerto Rican, Ecuadorian, Dominican and Portuguese.</p>			
<p>Sustainability Strategies: Require prenatal providers to routinely screen all patients. Tie this to reimbursement in collaboration with Medicaid MCOs. Track cost-benefits of screening. No additional funds needed.</p>			

Goal 2: Improve workforce knowledge and application of infant/early childhood mental health (IECMH) principles within child serving sectors—pediatric primary care and community-based settings, i.e.. HV, Head Start, early childhood education.			
Rationale: Current workforce needs to enhance understanding of IECMH principles that support the social-emotional and cognitive development of infants and young children, and their families.			
Objective 2.1: Pediatric/family practice primary care providers (PCP) will improve parent/family access to and use of pediatric primary care for assessment of infant/child social-emotional and behavioral health (BH).			
Targeted Outcomes: By Year 2, at least 5 PCPs will participate in health care provider trainings through the Pediatric Partnership Initiative (PPI) and/or Educating Physicians in the Community (EPIC) education sessions provided by AAP-NJ. In years 3-5, attain incremental increases each year (target for 4-year total of at least 10 participating PCPs). Practices will integrate behavioral health assessment into primary care setting, increasing likelihood that young child wellness issues are identified and addressed through on-site consultation or EPPC community linkages (HMG). [Note: At least 90% of children needing early intervention services and/or child mental health consultation/treatment will be linked, as needed.]			
Major Indicators: Complete an inventory of current PCPs (# sites / # children served / current BH practices); establish baseline #s. # of Essex providers agreeing to participate in Year 1 . and develop a plan to provide training and establish practice protocols in at least 10 PCPs in Year 2 with incremental increases over the remaining four years of the grant.			
General Strategy	Activities/Tasks	Stakeholders Responsible	Specific Timeframe
Conduct targeted trainings for social-emotional development and IECMH among pediatric health professionals and other EC stakeholders across the community.	<ul style="list-style-type: none"> Complete an inventory of current PCPs (# sites / # children served / current BH practices); establish baseline Identify participants in collaboration with NJAAP and YCW Council. Ensure input from/alignment with state partner efforts. Develop meeting plan, including frequency of meetings, location, facilitator, and agenda for first meeting (month?). Address training and implementation logistics (participants, location, etc.). Offer training to local primary care providers Track data, monitor progress & adjust (ongoing) Provide feedback from training/ implementation with the state to inform statewide expansion. 	YCWC screening workgroup, Essex YCW Coordinator, pediatric health professionals, NJ AAP, Medicaid MCOs, HV, EHS/HS, CCR&R, preschools, EI, and parents/ consumers State partners – DCF (ECCS/HMG), DOH, DHS, and DOE, NJCYC	Physician/partner outreach & training June-Sept 2014 Begin to implement October-December 2014
Policy Implications: Medical home/primary care screening will expand to include assessment of social emotional status with appropriate links to address early intervention, IECMH, behavioral health, and special education needs.			
Work Force Implications: Conduct local countywide trainings (perhaps bring Dr. Paul Dworkin, MD at HMG to present) to broaden outreach to interested pediatric/family practice providers on screening. Physicians (pediatric and family practice) and their practice staff will develop stronger linkages with EPPC central intake and other community partners.			
Coordination and Collaboration with the State: Input from relevant state-level groups, such as the NJCYC Infant/Child Health Committee and Central Intake Workgroup (ECCS/Help Me Grow, HV) to align with state efforts. Participation from NJ DCF, DOH, DHS, DOE, and other state partners.			

Coordination and Collaboration with other Stakeholders: MCH Consortium, AAP-NJ, NJAFP, FQHCs, IECMH association, local hospitals and clinics, and parents/families to increase social-emotional screening for infants and young children.
Addressing Behavioral Health Disparities: Early and routine screening will help to identify S-E delays, and provide opportunities to offer prevention education and earlier linkages for young children/families in need of special health/behavioral health and family support services.
Enhanced National CLAS Standards Alignment: Ensure cultural competency training for providers conducting screenings; and assess the need for communication and language assistance for parents/families. Particular attention will be given to ensure that services are responsive to the cultural and linguistic needs of sub-populations as identified in the DIS: African-Americans, Haitian and Nigerian immigrants; and predominant Hispanic/Latino ethnicities-- Puerto Rican, Ecuadorian, Dominican and Portuguese.
Sustainability Strategies: Require pediatric providers to routinely screen all patients. Tie this to reimbursement in collaboration with Medicaid MCOs and other insurers. Track cost-benefits of screening. No additional funds needed.

Objective 2.2: Early care and education (ECE) community providers will improve parent/family access to assessment of infant/child social-emotional and behavioral health (BH) and IECMH services. Early care staff participate in Infant Mental Health and Pyramid Model trainings			
Targeted Outcomes: Increased competence of ECE providers (home visitors, childcare providers, etc.) in social and emotional wellness of infants/young children. . By the end of Year 5 (Oct 2018), at least 50% of ECE staff in urban Essex County serving children/families from birth to age 8 will participate in a formal training of child social-emotional and cognitive development (IECMH and Pyramid Model trainings) and follow and established protocol for appropriate developmental activities, referral to community services, early intervention/special child health services, and/or child mental health consultation. Note: At least 80% of children identified with a developmental delay (in one or more subscales) will be appropriately referred for follow-up IECMH assessment.			
Major Indicators: Complete an inventory of current urban Essex childcare center providers (# sites / # children served / current screening/follow-up training and practices); establish baseline (0), and develop a plan to provide training and establish practice protocols in at least 8 centers annually over the remaining four years of the grant (align with Grow NJ Kids). Participation of ECE providers in <i>Keeping Babies & Children in Mind</i> (MSU-Montclair State University) training.			
General Strategy	Activities/Tasks	Stakeholders Responsible	Specific Timeframe
Coordinate training in infant and early childhood mental health throughout the four cities for community-based infant & early childhood partners/early care providers (non-physicians).	<ul style="list-style-type: none"> • Inventory current EC sites (# type of sites / # children served) - establish baseline • Identify participants in collaboration with YCWC partners. Ensure input from/alignment with state partner efforts. • Working with MSU to develop training schedule and advertise to targeted networks in Irvington, E. Orange, Orange and Newark, with a goal of rotating trainings throughout the four cities (May-September 2014) • Offer training to local EC providers—HV, child care, FCCP, EHS/HS, preschools, EI, etc. (June-October 2014) – identify at least 8 participating centers. • Promote completion of the IMH Endorsement and Pyramid model trainings. • Track data, monitor progress & adjust (ongoing) • Provide feedback from training/implementation to inform statewide expansion. 	YCWC screening workgroup, Essex YCW Coordinator MSU, NJ-AIMH, IECMH workgroup,, NIEER, Medicaid MCOs, HV, EHS/HS, CCR&R, preschools, EI, and parents/consumers State partners – NJPL, DCF (ECCS/HMG), DOH, DHS, and DOE, NJCYC	EC partner outreach & training June-Sept 2014 Begin to implement October-December 2014

<p>Policy Implications: The local system of care will support routine screening in early childhood settings of social emotional status with appropriate communication and links to the child’s pediatric provider/medical home; and will have easy linkages to address early intervention, IECMH, behavioral health, and special education needs.</p>
<p>Work Force Implications: Home visitors, childcare directors and staff, Early Head Start/Head Start, Early Intervention, preschools, Family Outreach, child welfare offices, Family Success Centers and elementary school teachers will have access to trainings throughout Essex County. Attendees will receive professional education, training coaching and supervision in evidenced based practices and curricula which support the social, emotional, and neurological foundations for all development in learning, including topics on promoting IECMH responding to trauma, supporting children and family strengthening and utilizing reflective practices. Completion of training will prepare participants for Level I and Level II Endorsement from NJ-AIMH.</p>
<p>Coordination and Collaboration with the State: Input from relevant state-level groups, such as the NJCYC Infant/Child Health Committee and Central Intake Workgroup (ECCS/Help Me Grow, HV) to align with state efforts. Participation from NJ DCF, DOH, DHS, DOE, and other state partners.</p>
<p>Coordination and Collaboration with other Stakeholders: MCH Consortium, AAP-NJ, NJAFP, FQHCs, IECMH association, local hospitals and clinics, and parents/families to increase social-emotional screening for infants and young children.</p>
<p>Addressing Behavioral Health Disparities: Foundational training and support to promote early and routine screening will help to promote social-emotional development; and identify S-E delays. It will also provide opportunities to offer prevention education and earlier linkages for young children/families in need of special health/behavioral health and family support services.</p>
<p>Enhanced National CLAS Standards Alignment: Ensure cultural competency training for EC providers; assess need for communication & language assistance for parents/families. Particular attention to ensure that services are responsive to the cultural and linguistic needs of sub-populations as identified in the DIS: African-Americans, Haitian and Nigerian immigrants; and predominant Hispanic/Latino ethnicities--Puerto Rican, Ecuadorian, Dominican and Portuguese.</p>
<p>Sustainability Strategies: Require EC providers to participate in training (component of NJ’s Race to the Top-Early Learning Challenge grant) for the tiered Quality Rating Improvement System (Grow NJ Kids). Higher tiers also require routine screening. Track cost-benefits of enhanced social emotional skills and screening. No additional funds needed.</p>

<p>Goal 3: Ensure that parents/families have access to a continuum of community-based evidence-based programs (EBP) that support parent-child interaction and young child development, with a special focus on infant/young child social-emotional health and wellness.</p>			
<p>Rationale: Essex has an abundance of community services--more focus is needed on EBP. Parents and providers need easier access to a coordinated system of care for young children (birth to age 8) that optimize linkages to EBPs, service referrals and community supports.</p>			
<p>Objectives: Increase referrals for pregnant women and families of children from birth to age 8 to a network of community services through the EPPC central intake that include—Objective 3.1: Evidence-based Home Visiting; and Objective 3.2: Alternate Community Based Early Childhood/Family Support Settings:</p> <p>Objective 3.1: Increase the success of current Essex HV programs in reaching NJ’s established participation rate and HV performance benchmarks for parents/families with children pregnancy/birth to age 3.</p> <p>Objective 3.2: Increase access for Essex County parents/ families with children (birth to age 8) to alternate community-based early childhood/family support settings—to include newly funded Essex LAUNCH EBPs (TBD) Early Head Start/Head Start, Family Success Centers, Child Care, Family Child Care, Preschool, etc.</p>			
<p>Targeted Outcomes: In Years 2 thru 5, EPPC central intake will increase community partner referrals, by <i>at least</i> 40% per year. Baseline for 2013=1,200 families annually (includes pregnant women). Target: total of <i>at least</i> 5,000 families with children 0-8 who are referred to services through EPPC by 2018.</p> <p>3.1 – HV programs will remain at least at 80% or above of capacity (local data is available for baseline)</p> <p>3.2 – Other community programs will report increased referrals and participation (local data is available for baseline)</p>			
<p>Major Indicators: In Year 1, complete an inventory of current referrals (# sites / # families / types of services, etc.) to establish baseline. Use established quarterly reports and SPECT data system to determine baseline and track increases in system-wide utilization of EPPC central intake services by prenatal, pediatric and other community partners; as well as parents/families.</p>			
General Strategy	Activities/Tasks	Stakeholders Responsible	Specific Timeframe
<p>Conduct targeted training of providers and other stakeholders across the community on value of having links to EBPs and other needed community supports.</p>	<ul style="list-style-type: none"> ● Use current data to complete inventory of current use of EPPC-central intake (May-July) ● Identify new community partners to join YCW Council and promote EPPC, include state participation to ensure alignment with state efforts (thru June 2014). ● Develop meeting plan, include meeting frequency, location, facilitator, & agenda Hold monthly meetings (June-Sept). ● Issue RFP for new EBPs—selection and start-up (July 2014) ● Begin core model training and start-up logistics (July-Oct 2014). ● Establish fidelity and performance benchmarks for new EBPs. (July-December 2014). ● Track data, monitor progress & adjust (ongoing) ● Feedback from training/ implementation with the state oversight to inform next steps. 	<p>Local YCWC prenatal & pediatric providers, MCH Consortium, CHWs, EPPC staff, Medicaid MCOs, Improving Pregnancy Outcomes (IPO) partners, EHS/HS, CCR&R, preschools, Early Intervention (EI), & faith community, civic groups, and parents/ consumers</p> <p>State partners – DCF (ECCS/HMG), DOH, DHS, Family Health Initiatives (SPECT System), March of Dimes, AAPNJ, NJCYC.</p>	<p>Community outreach and training-- June-Sept 2014</p> <p>Begin Year 2 tracking (quarterly) —October 2014</p> <p>Increase use of EPPC (Central Intake) by end of Qtr 1 (Dec 2014)</p>

<p>Policy Implications: Coordination with State partners to promote routine use of the PRA (including the 4 P's Plus) as a component of quality prenatal care. Consider efforts to incentivize 4 Ps Plus screening for prenatal care providers currently not using tool. Collaboration with related partners— NJ Medicaid MCOs, March of Dimes, ACOG/physician groups, and others-- to increase PRA usage in hospital/community-based clinics, FQHCs, and private care settings.</p>
<p>Work Force Implications: Conduct local countywide training (perhaps bring Dr. Ira Chasnoff to present to physician partners) to broaden outreach to interested prenatal providers on 4 Ps. Build linkages with other champions NJ Section of ACOG to expand PRA use and compliance.</p>
<p>Coordination and Collaboration with the State: Input from relevant state-level groups, such as the NJCYC Infant/Child Health Committee and Central Intake Workgroup (ECCS,/HMG, HV) to align with state efforts. Participation from NJ DCF, DOH, DHS, and Family Health Initiatives (SPECT training/ support).</p>
<p>Coordination and Collaboration with other Stakeholders: MCH Consortium, ACOG-NJ Section, ACNM-NJ Section, AWOHNN, FQHCs, Centering Pregnancy/Strong Start sites, University Hospital, Newark Beth Israel to increase PRA use for pregnant women</p>
<p>Addressing Behavioral Health Disparities: PRA and 4 P's Plus will help to identify risk factors, and provide opportunities to offer prevention education and earlier linkages for pregnant and parenting women/families in need of health/behavioral health and family support services.</p>
<p>Enhanced National CLAS Standards Alignment: Ensure cultural competency training for providers conducting screenings; and assess the need for communication and language assistance for parents/families. Particular attention in will be given to ensure that services are responsive to the cultural and linguistic needs of sub-populations as identified in the DIS: African-Americans, Haitian and Nigerian immigrants; and the predominant Hispanic/Latino ethnicities--Puerto Rican, Ecuadorian, Dominican and Portuguese.</p>
<p>Sustainability Strategies: Require prenatal providers to routinely screen all patients. Tie this to reimbursement in collaboration with Medicaid MCOs. Track cost-benefits of screening. No additional funds needed.</p>

<p>Goal 4: Increase opportunities for family strengthening programs and parent/family leadership development.</p>
<p>Rationale: Tremendous need for family strengthening services and supports that empower families (mothers, fathers, grandparents, other family supports) to be more engaged and involved to contribute their input and ensure a comprehensive, integrated system of care that is culturally- and linguistically-competent, equitable, respectful, and responsive to the diversity of our community.</p>
<p>Objective 4.1: Develop a stronger participatory/advisory role for parents/families using the Strengthening Families (SF) Protective Factors framework.</p>
<p>Targeted Outcomes: Essex County will have a robust coordinated system of care for children, birth to age 8, with opportunities for family strengthening, parent training, and parent/family advocacy and leadership. The Essex County Council for Young Children (local YCW Council) will have active countywide representation from local providers and advocates for young children, with at least 51% of the council consisting of parents/grandparents or other family members of young children from the four target cities.</p>
<p>Major Indicators: New parent attendance, ongoing parent participation, subset of parent leaders. Families/consumers are actively involved in leadership and the decision making process regarding programs and practices that impact young child wellness in urban Essex County.</p>

General Strategy	Activities/Tasks	Stakeholders Responsible	Specific Timeframe
Parent/family strengthening Parent leadership development	<ul style="list-style-type: none"> • Inventory of current parent groups, family strengthening programs (May-July) • Identify new community partners to join YCW Council and promote EPPC, include state participation to ensure alignment with state efforts (thru June). • Develop meeting plan, include meeting frequency, location, facilitator, & agenda Hold monthly meetings (June-Sept). • Issue RFP (DCF) to include parent/family strengthening programs in Essex— select and start-up (July 2014) • Core model training and start-up logistics (participants, location, etc.) (July-October 2014). • Establish fidelity & performance benchmarks for new EBPs. (July-Dec 2014). • RTT-ELC RFP (DCF) will provide funds for County Council family engagement and parent leadership development. • Track data, monitor progress & adjust (ongoing) • Feedback from training/implementation with state oversight to inform next steps. 	CHWs, EPPC staff, Local YCWC health & social service providers, MCH Consortium, Medicaid MCOs, IPO partners, EHS/HS, CCR&R, preschools, Early Intervention (EI), faith community, civic groups, and parents/ consumers State partners – DCF (ECCS/HMG), DOH, DHS, Family Health Initiatives (SPECT System), March of Dimes, AAPNJ, NJCYC.	Community outreach and core training-- June-Sept 2014 Increase parent participation by end of Qtr 1 (October to December 2014) Parent leadership training/mentoring -ongoing
<p>Policy Implications: Coordination with State partners to promote family engagement, parent leadership and family strengthening as a component of RTT-ELC Grant. DCF will oversee statewide expansion of county councils, so the work in Essex LAUNCH will help to inform state expansion.</p>			
<p>Work Force Implications: Conduct local countywide trainings for the EC workforce on effective family engagement. Integrate SF Protective factors training. Also, work directly with parents/families to build parent leadership and family strengthening across early childhood sectors. This will help to improve parent participation and retention in community-based services, e.g. HV, EHS/HS, quality child care, EI, etc.</p>			
<p>Coordination and Collaboration with the State: Input from relevant state-level groups, such as the NJCYC Infant/Child Health Committee, Family Engagement and Outreach Committee to align with state efforts. Participation from NJ DCF, DOH, DHS, and DOE.</p>			
<p>Coordination and Collaboration with other Stakeholders: Community Health Workers, Outreach Programs, MCH Consortium, Faith Community, Family Success Centers, SPAN, Parents Anonymous, Family Support Organizations, United Way Agencies, CCR&Rs, Schools, Family Outreach Program, and others.</p>			
<p>Addressing Behavioral Health Disparities: Greater parent and family involvement will help to better understand and mitigate risk factors, build family strengths and protective factors, and provide opportunities to offer prevention education and earlier linkages for pregnant and parenting women/families in need of health/behavioral health and family support services.</p>			
<p>Enhanced National CLAS Standards Alignment: Ensure cultural competency training for community providers; assess need for communication & language assistance for parents/families. Particular attention to ensure that services are responsive to the cultural and linguistic needs of sub-populations as identified in the DIS: African-Americans, Haitian and Nigerian immigrants; and Hispanic/Latino ethnicities--Puerto Rican, Ecuadorian, Dominican and Portuguese.</p>			
<p>Sustainability Strategies: Start-up funds from RTT-ELC (thru Dec 2018) and Project LAUNCH (thru Aug 2018). DCF will provide close oversight and technical support to ensure success. Track cost-benefits of strengthening parent/family participation and leadership. Possible sustaining funds from federal Community Based Child Abuse Prevention (CBCAP) grant and local private foundation support.</p>			

New Jersey Project LAUNCH Logic Model

GOALS	Inputs What we invest...	Outputs What we do...	Intermediate Outcomes	Long-Term Outcomes	Data & Measurement
<ul style="list-style-type: none"> • Improve access to services within an integrated system of care EC across sectors • Increase routine screening of child development (ASQ/ASQ:SE) • Increase routine prenatal screening (PRA-4 P's Plus) for ATOD use, MH & DV • Improve EC workforce knowledge & application of infant/early childhood mental health (IECMH) • Pediatric primary care providers participate in ECCS/Help Me Grow • Early childhood (EC) staff participate in training & workforce development • Expand EBPs that support parent-child interaction and young child development • Increase referrals for pregnant women & children to age 8 to central intake • Increase referrals to evidence-based HV and alternate community-based family support settings • Increase opportunities for family strengthening and parent/family leadership 	<ul style="list-style-type: none"> • Essex Pregnancy & Parenting Connection (EPPC) • State(DCF) & Local (PCANJ) YCW Coordinators • EBHV programs--Nurse Family Partnership (NFP) Healthy Families (HF), Parents As Teachers (PAT) • Family Success Centers (FSC) • Early Head Start & Head Start (EHS/HS) • Regional EI Center (REIC) • Family Support Organization of Essex (FSO) • Montclair State University (MSU) • Mental health and child serving agencies • Public school districts/charter schools • Private and parochial schools • Faith-based organizations • Bilingual health & social service professionals • Essex area health providers—physicians, nurses • Federally Qualified Health Center (FQHC) • Essex area social service providers • Municipal leaders, legislators, policy-makers • Outreach partners/ Family Resource Workers, Community Health Workers (CHW) • Local CDCs and non-profit leaders • State and local foundations/funders • Pregnant women, parents, grandparents, families • Infants & children to 8 years of age / siblings • State-level partners--DCF, DHS, DOE, DOE • Align current state initiatives—ECCS, HMG, RTT-ELC, NJCYC, • Early childhood (EC) advocacy groups • Higher education partners (workforce & parents) • American Academy of Pediatrics NJ (AAPNJ) • Statewide Parenting Advocacy Network (SPAN) • Child Care Resource & Referral (CCR&R) • Other public and private stakeholders • Johns Hopkins University (JHU) 	<ul style="list-style-type: none"> • Promote public awareness & family involvement in Essex LAUNCH and EPPC • Provide outreach to prenatal & pediatric providers • Assure links for pregnant women (Perinatal Screening & Risk Assessment (PRA)) • Assure links for children ages Birth to 8, and their families (child developmental screening) • EC professional development trainings to across sectors – promote IMH-E and Pyramid • Issue RFP to promote & spread evidence-based practices (EBP) • Develop policies to inform, educate and empower • Collaborate and consult with state & community partners— • Administer EBP tools and services at specific intervals for targeted infants and children • Outreach to pregnant women and parents of young children • Develop a system of care and referral that aligns with State efforts-DCF, DOH, DHS & DOE • Families and educators work collaboratively to develop educational goals • Establish data systems and reporting to document progress • Essex LAUNCH advisory body—YCW Council • PL Evaluation: JHU & partners develop evaluation plan 	<p>Among participants--</p> <ul style="list-style-type: none"> • Routine PRA screening • Adequate prenatal care • Early service links for behavioral health (ATOD, MH, DV, other supports) • Child health insurance • Pediatric medical home, • Child developmental screening, including SE • Early identification of developmental delays • Early links to health & social supports—i.e. home visiting (HF, NFP, PAT), EHS/HS, child care (subsidy for low income families) • Earlier links to IECMH, child BH services, REIC/early intervention, special educ; or other child/family support. • Better coordination of intervention resources • Increase parent/family engagement/retention • Improve parent/family involvement in service & education goals • Policy/practice changes for children & families • Increase parent leadership on agencies and boards • Improve data-driven agency decisions 	<ul style="list-style-type: none"> • Population health improvements • Healthy pregnancy / birth outcomes • Reduce health disparities • Reduce educational disparities • Coordinated, comprehensive, health care system (including social-emotional health) for children ages B to 8 and their families • System accountability for promotion, prevention & family support services • Reduce racial and ethnic disparities in child health, MH/BH, child welfare and education • Increase resource base & eliminate referral redundancy • Establish continuity between early childhood and school-age educational agencies • Track performance outcomes for CQI utilizing integrated data systems 	<ul style="list-style-type: none"> • Partnership Survey • SF Protective Factor Survey • PRA data–SPECT system • Referral & linkage • Feedback forms • Participant satisfaction survey • EC workforce survey (IECMH) • 4P's Plus • Edinburgh Scale • ASQ-3 / ASQ:SE • Other valid & reliable tools • DCF quarterly progress reports • EBP specific data (e.g. NFP, HF, PAT, EHS/HS) • SPECT continual tracking of # of screens /referrals • Ongoing log of local level activities • Parent/family participation and leadership • Systems impact (data agreements) i.e. Health, HV, ECE, EI, BH CPS, etc.

External Factors -- positive and negative influences, culture, economics, politics, demographics